DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 — 0 2 3

2. STATE: MONTANA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
JULY 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 (250-272)

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ 6,344,858'
b. FFY 2004 $15,447, 500

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

4.19 D	16 of 56	52 of 56
2 of 56	17 of 56	53 of 56
4 of 56	30 of 56	54 of 56
8 of 56	38 of 56	
12 of 56	42 of 56	
13 of 56	43 of 56	

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

4.19 D		
2 of 56	16 of 56	43 of 56
4 of 56	17 of 56	52 of 56
8 of 56	30 of 56	53 of 56
12 of 56	38 of 56	54 of 56
13 of 56	42 of 56	

10. SUBJECT OF AMENDMENT:

NURSING FACILITY REIMBURSEMENT

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Single State Agency Director

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Gail Gray

13. TYPED NAME:
Gail Gray

14. TITLE:
Director

15. DATE SUBMITTED:
~~September 22, 2003~~

16. RETURN TO:
Department of Public Health and Human Services
Gail Gray Director
Attention: Kelly Williams
P O Box 4210
Helena MT 59604

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 23 2003

18. DATE APPROVED: MAY 19 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Dennis G Smith

21. TYPED NAME:
Dennis G. Smith

22. TITLE:
Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

INDEX TO NEW NURSING FACILITY MEDICAID RULE SECTIONS

37.40.331	Items Billable to Residents
37.40.336	Reimbursement for Intermediate Care Facilities for the Mentally Retarded
37.40.337	Reimbursement to Out-of-State Facilities
37.40.338	Bed Hold Payments
37.40.339	Medicare Hospice Benefit - Reimbursement
37.40.345	Allowable Costs
37.40.346	Cost Reporting, Desk Review & Audit
37.40.347	Cost Settlement Procedures
37.40.351	Third Party Payments and Payment in Full
37.40.352	Utilization Review & Quality of Care
37.40.360	Lien and Estate Recovery Funds for One -Time Expenditures (Repealed)
37.40.361	Direct Care Wage Reporting
37.5.310	Administrative Review & Fair Hearing Process for Medical Assistance Providers

(5) "Estimated economic life" means the estimated remaining period during which property is expected to be economically usable by one or more users, with normal repairs and maintenance, for the purpose for which it was intended when built.

(6) "Fiscal year" and "fiscal reporting period" both mean the provider's internal revenue tax year.

(7) "Maintenance therapy and rehabilitation services" mean repetitive services required to maintain functions which do not involve complex and sophisticated therapy procedures or the judgment and skill of a qualified therapist and without the expectation of significant progress.

(8) "Medicaid recipient" means a person who is eligible and receiving assistance under Title XIX of the Social Security Act for nursing facility services.

(9) "Minimum data set (MDS)" means the assessment form approved by the centers for medicare and medicaid services (CMS), and designated by the department to satisfy conditions of participation in the medicaid and medicare programs.

(10) "Minimum data set RUG-III quarterly assessment form" means the three page quarterly, optional version for RUG-III 1997 update.

(11) "Nonemergency routine transportation" means transportation for routine activities, such as outings scheduled by the facility, nonemergency visits to physicians, dentists, optometrists or other medical providers. This definition includes such transportation when it is provided within 20 miles of the facility.

(12) "Nursing facility services" means nursing facility services provided in accordance with 42 CFR, part 483, subpart B, or intermediate care facility services for the mentally retarded provided in accordance with 42 CFR, part 483, subpart I. The department hereby adopts and incorporates herein by reference 42 CFR, part 483, subparts B and I, which define the participation requirements for nursing facility and intermediate care facility for the mentally retarded (ICF/MR) providers, copies of which may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. The term "nursing facility services" includes the term "long term care facility services". Nursing facility services include, but are not limited to, a medically necessary room, dietary services

37.40.331);

(xxii) raised toilet seat;

(xxiii) sitz baths;

(xxiv) suction machines;

(xxv) tourniquets;

(xxvi) traction equipment;

(xxvii) trapeze bars;

(xxviii) vaporizers, steam-type;

(xxix) walkers (regular and wheeled);

(xxx) wheelchairs (standard);

(xxxi) whirlpool bath;

(g) laundry services whether provided by the facility or by a hired firm, except for residents' personal clothing which is dry cleaned outside of the facility; and

(h) nonemergency routine transportation as defined in (14).

(13) "Patient contribution" means the total of all of a resident's income from any source available to pay the cost of care, less the resident's personal needs allowance. The patient contribution includes a resident's incurment determined in accordance with applicable eligibility rules.

(14) "Patient day" means a whole 24-hour period that a person is present and receiving nursing facility services, regardless of the payment source. Even though a person may not be present for a whole 24-hour period on the day of admission or day of death, such day will be considered a patient day. When department rules provide for the reservation of a bed for a resident who takes a temporary leave from a provider to be hospitalized or make a home visit, such whole 24-hour periods of absence will be considered patient days.

(15) "Provider" means any person, agency, corporation, partnership or other entity that, under a written agreement with the department, furnishes nursing facility services to medicaid recipients.

(16) "Rate year" means a 12-month period beginning July 1. For example, rate year 2004 means a period corresponding to the state fiscal year July 1, 2003 through June 30, 2004.

(17) "Resident" means a person admitted to a nursing facility who has been present in the facility for at least one 24-hour period.

(18) "RUG-III" means resource utilization group, version III.

483.12(a)(4), (5) and (6). The notice must be provided using the form prescribed by the department. In addition to the notice contents required by 42 CFR 483.12, the notice must inform the recipient of the recipient's right to a hearing, the method by which the recipient may obtain a hearing and that the recipient may represent herself or himself or may be represented by legal counsel, a relative, a friend or other spokesperson. Notice forms are available upon request from the department. Requests for notice forms may be made to the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. (History: Sec. 53-6-108, 53-6-111, 53-6-113 and 53-6-189, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-106, 53-6-107, 53-6-111, 53-6-113 and 53-6-168, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

37.40.307 NURSING FACILITY REIMBURSEMENT (1) For nursing facility services, other than ICF/MR services, provided by nursing facilities located within the state of Montana, the Montana medicaid program will pay a provider, for each medicaid patient day, a per diem rate determined in accordance with this rule, minus the amount of the medicaid recipient's patient contribution.

(2) Effective July 1, 2001, and in subsequent rate years, nursing facilities will be reimbursed using a price-based reimbursement methodology. The rate for each facility will be determined using the operating component defined in (2)(a) and the direct resident care component defined in (2)(b):

(a) The operating component is the same per diem for each nursing facility. It is set at 80% of the statewide price for nursing facility services.

(b) The direct resident care component of each facility's rate is 20% of the overall statewide price for nursing facility services. It is adjusted for the acuity of the medicaid residents served in each facility. The acuity adjustment increases or decreases the direct resident care component in proportion to the relationship between each facility's medicaid

average case mix index and the statewide average medicaid case mix index.

(i) The medicaid average case mix index for each facility to be used in rate setting will be the simple average of each facility's four medicaid case mix indices calculated for the periods of February 1 of the current year and November 1, August 1 and May 1 of the year immediately preceding the current year. The statewide average medicaid case mix index will be the weighted average of each facility's four quarter average medicaid case mix index to be used in rate setting.

(c) The statewide price for nursing facility services will be determined each year though a public process. Factors that could be considered in the establishment of this price include the cost of providing nursing facility services, medicaid recipients access to nursing facility services, and the quality of nursing facility care.

(d) The total payment rate available for the period July 1, 2001 through June 30, 2002 will be the rate as computed in (5), plus any additional amount computed in ARM 37.40.311.

(3) For providers who, as of July 1 of the rate year, have not filed with the department a cost report covering a period of at least six months participation in the medicaid program in a newly constructed facility shall have a rate set at the statewide median price as computed on July 1, 2001 for this transition year. Following a change in provider as defined in ARM 37.40.325, the per diem rate for the new provider shall be set at the previous provider's rate, as if no change in provider had occurred.

(4) For ICF/MR services provided by nursing facilities

subchapter, until the effective date of a new rate established in accordance with a new rule or amendment to these rules, adopted after the establishment of the current rate, which specifically provides a rate methodology for the new or subsequent rate year. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

Rules 09 and 10 reserved

37.40.311 RATE ADJUSTMENT FOR COUNTY FUNDED RURAL NURSING FACILITIES (1) For state fiscal year 2004 and 2005, the department will provide a mechanism for a one time, lump sum payment to non-state governmental owned or operated facilities for medicaid services. These payments will be for the purpose of maintaining access and viability for a class of "at risk" county affiliated facilities who are predominately rural and are the only nursing facility in their community or county or who provide a significant share of nursing facility services in their community or county.

(a) A nursing facility is eligible to participate in this lump sum payment distribution if it is a non-state governmental owned or operated facility.

(b) The department will calculate the amount of lump sum distribution that will be allowed for each county affiliated provider so that the total per day amount does not exceed the computed medicare upper payment limit for these providers. Distribution of these lump sum payments will be based on the medicaid utilization at each participating facility for the period July 1, 2003 through June 30, 2004 and July 1, 2004 through June 30, 2005.

(c) In order to qualify for this lump sum adjustment effective July 1, 2003 through the end date of June 30, 2005, each non-state governmental owned or operated facility must enter into a written agreement to transfer local county funds to be used as matching funds by the department. This transfer option is voluntary, but those facilities that agree to participate must abide by the terms of the written agreement.

(2) Effective for the period commencing on or after July 1, 2003 through June 30, 2005, the department will provide for a one time, lump sum distribution of funding to nursing facilities not participating in the funding for "at risk" facilities for the provision of medicaid services.

(a) The department will calculate the maximum amount of the lump sum payments that will be allowed for each participating non-state governmental owned or operated facility, as well as the additional payments for other nursing facilities not participating in the funding for "at risk" facilities for the provision of medicaid services, in accordance with state and federal laws, as well as applicable medicare upper payment limit thresholds. This payment will be computed as a per day add-on based upon the funding available. Distribution will be in the form of lump sum payments and will be based on the medicaid utilization at each participating facility for the period July 1, 2003 through June 30, 2004 and from July 1, 2004 through June 30, 2005. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02; AMD, 2003 MAR p. 1294, Eff. 7/1/03.)

Rule 12 reserved

37.40.313 OPERATING COST COMPONENT (REPEALED) (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 685, Eff. 4/30/93; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 1044, Eff. 6/24/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; REP, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.314 DIRECT NURSING PERSONNEL COST COMPONENT (REPEALED) (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995

medicaid services division. Approvals will be effective for 1 month intervals and reapproval must be obtained monthly.

(b) The department may require the provider to submit any appropriate medical and other documentation to support a request for authorization of the increment. Each calendar month, the provider must submit to the department, together with reporting forms and according to instructions supplied by the department, time records of nursing services provided to the resident during a period of five consecutive days. The submitted time records must identify the amount of time care is provided by each type of nursing staff, i.e., licensed and non-licensed.

(c) The increment amount shall be determined by the department as follows. The department shall subtract the facility's current average medicaid case mix index (CMI) used for rate setting determined in accordance with ARM 37.40.320 from the CMI computed for the ventilator dependent resident, determined based upon the current minimum data set (MDS) information for the resident in order to determine the difference in case mix for this resident from the average case mix for all medicaid residents in the facility. The increment shall be determined by the department by multiplying the provider's direct resident care component by the ratio of the resident's CMI to the facility's average medicaid CMI to compute the adjusted rate for the resident. The department will determine the increment for each resident monthly after review of case mix information and five consecutive day nursing time documentation review.

(3) The department will reimburse for separately billable items at direct cost, with no indirect charges or mark-up added. For purposes of combined facilities providing these items through the hospital portion of the facility, direct cost will mean invoice price to the hospital with no indirect cost added.

(a) If the items listed in (1)(a) through (1)(de) are also covered by the medicare program and provided to a medicaid recipient who is also a medicare recipient, reimbursement will be limited to the lower of the medicare prevailing charge or the amount allowed under (3). Such items may not be billed to the medicaid program for days of service for which medicare Part A coverage is in effect.

(b) The department will reimburse for separately billable items only for a particular resident, where such items are medically necessary for the resident and have been prescribed by